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PROCEEDINGS OF THE ANNUAL CONFERENCE OF THE SURGEON GENERAL PUBLIC HEALTH SERVICE AND CHIEF, CHILDREN'S BUREAU WITH STATE AND TERRITORIAL HEALTH OFFICERS, STATE MENTAL HEALTH AUTHORITIES AND REPRESENTATIVES OF STATE HOSPITAL SURVEY AND CONSTRUCTION AGENCIES (52nd). HELD AT WASHINGTON, D. C. ON 5-7 NOVEMBER 1953

Public Health Service
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1954

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FIFTY-SECOND ANNUAL CONFERENCE

1953

SURGEON GENERAL
PUBLIC HEALTH SERVICE
AND
CHIEF, CHILDREN'S BUREAU
WITH
STATE AND TERRITORIAL HEALTH OFFICIALS

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

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PROCEEDINGS

FIFTY-SECOND ANNUAL CONFERENCE

OF THE

SURGEON GENERAL
PUBLIC HEALTH SERVICE

AND

CHIEF, CHILDREN'S BUREAU

WITH

STATE AND TERRITORIAL HEALTH OFFICERS

STATE MENTAL HEALTH AUTHORITIES

AND

REPRESENTATIVES OF

STATE HOSPITAL SURVEY AND CONSTRUCTION AGENCIES

November 5-7, 1953

Washington, D. C.

Issued by
U. S. Department of Health, Education, and Welfare

NOTE: The annual meeting of the Association of State and Territorial Health Officers, held simultaneously with this Conference, will be reported separately by the Association. This Proceedings reports only those sessions and recommendations which were a part of the General Conference.

Public Health Service Publication No. 338

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of the

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS

1953 - 1954

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ARTHUR THOMAS McCORMACK AWARD

Dr. Robert H. Riley, Director of Public Health of Maryland, received the Arthur T. McCormack Award for meritorious public health work from Dr. Roy L. Cleere, Vice-Chairman of the Award Committee of the Association of State and Territorial Health Officers.

Other recipients of this award, honoring the name of the former State Health Commissioner for Kentucky, have been:

Dr. Walter L. Bierring, Iowa Commissioner of Health since 1933, and former President of the Iowa State Board of Health and State Board of Medical Examiners from 1914 to 1922.

Dr. Albert J. Chesley, Secretary and Executive Officer of the Minnesota State Board of Health since 1921, and an associate of the State Board of Health since 1902.

Dr. Stanley H. Osborn, Connecticut Commissioner of Health since 1922, and former District Health Officer in Massachusetts.

Dr. Felix J. Underwood, State Health Officer of Mississippi since 1924, and promoter of the new School of Medicine of the University of Mississippi. Dr. J. A. Milne accepted the award in Dr. Underwood's absence.

Dr. Edward S. Godfrey, State Health Officer of the Territory of Arizona from 1908 to 1912, and of New York State from 1936 to 1947. In the absence of Dr. Godfrey, Dr. H. E. Hilleboe accepted the award for presentation to him.

The late Dr. Cornelius A. Harper, Wisconsin State Health Officer from 1904 to 1939. Dr. C. N. Neupert accepted the award for presentation to the family of Dr. Harper.

Dr. Thomas F. Abercrombie, first county health officer in Georgia; lifetime Director Emeritus of the Georgia State Department of Public Health; and former State Health Officer of Georgia from 1917 to 1947.

Dr. Earle G. Brown, Health Commissioner, Nassau County, New York, since 1938; former Health Officer and Director of Welfare, Arlington County, Virginia, 1937-38; Secretary and Excutive Officer, Kansas State Board of Health, 1925 to 1933; and City Health Officer, Topeka, Kansas, 1919 to 1925.

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GENERAL SESSION, NOVEMBER 5, 1953

with the

PUBLIC HEALTH SERVICE and the CHILDREN'S BUREAU

(Dr. Leonard A. Scheele, Surgeon General, Public Health Service, presiding.)

DR. SCHEELE: Ladies and gentlemen, this is the Fifty-Second Annual Conference of the Surgeon General of the Public Health Service and the Chief of the Children's Bureau with State and Territorial Health Officers, the State Mental Health Authorities, and Representatives of State Hospital Survey and Construction Agencies, Department of Health, Education, and Welfare.

I have one brief announcement to make. The President has announced a city-wide Civil Defense drill in the metropolitan area of Washington today, and he has directed each Department of the Government to participate in this drill. In keeping with that request, the National Institutes of Health, including us in Wilson Hall, will participate in the exercise.

At 9:30, a yellow alert was sounded, and we anticipate that there will be a red alert around 10:00 o'clock this morning, and upon that signal we will proceed immediately by the stairway to the appropriate shelter area in this building. There will be wardens, who will direct us.

Anyone who has any infirmity, who requires assistance and cannot negotiate the stairs, will use the elevator. We expect the all clear to be sounded at 10:15, and we will come back promptly to Wilson Hall and proceed with the program.

I am happy to welcome the representatives of the Air Force, of the Army, Department of Defense, Federal Defense Administration, Department of Indian Affairs, Department of Navy, Veterans' Administration, American Medical Association, members of the press, and all others who are participating in our meeting.

First, I should like to introduce among the folks on the program Dr. Chester Keefer, who is Special Assistant to the Secretary for Health and Medical Affairs. Dr. Keefer.

(Applause)

DR. SCHEELE: I want to give you some of Dr. Keefer's background, but we will reserve that for the Toastmaster of the banquet this evening, where Dr. Keefer will be the speaker.

Next, I should like to introduce the man who will address us this morning, Mr. Nelson Rockefeller. Mr. Rockefeller is known to everyone in this room. His activities are of great interest to us as related to the field of health, education, and welfare work. I will mention just a few.

He was founder and first president of the International Basic Economy Corporation, and also of the American International Association for Economic and Social Development. These organizations, which he helped establish, have been raising living standards in underdeveloped areas.

In August 1940, President Roosevelt appointed him as Coordinator of Commercial and Cultural Relations between the American Republics. The name of that organization was changed twice by Executive Order to the name of Office of Inter-American Affairs. During this period, Mr. Rockefeller was Assistant Secretary of State in Charge of Relations of the American Republics, and is therefore not a newcomer to health, education, and welfare programs.

In November 1950, President Truman appointed Mr. Rockefeller Chairman of the newly created International Development Advisory Board which was charged with recommending general policy for underdeveloped areas. He served for a year, during which time the Board published its conclusions regarding roles of private capital and public funds, entitled "Partners in Progress."

It is of interest to this group to know, too, that Dr. Thomas Parran, former Surgeon General of the U. S. Public Health Service, was a member of the same International Development Advisory Board.

In November 1952, President-elect Eisenhower appointed Mr. Rockefeller Chairman of the three-man committee to represent him for reviewing studies for streamlining the Executive Branch of the Government.

The President's first Executive Order on January 24, 1953, gave official status to his Advisory Committee on Government Organization, with continuing responsibility for recommending changes in management which would promote greater economy and efficiency; and I believe that Board is still in existence.

Finally, Mr. Rockefeller was appointed by President Eisenhower on June 11, this year, to the position of Under Secretary of the Department of Health, Education, and Welfare.

It is a great pleasure to introduce to you Mr. Nelson Rockefeller.

(Applause)

ADDRESS

Nelson A. Rockefeller, Under Secretary
U. S. Department of Health, Education, and Welfare

Dr. Scheele and Members of the Fifty-Second Conference, I need not say it is a special pleasure for me to be here with you. I owe this privilege to a previous commitment of Secretary Hobby. Otherwise, she would be addressing you. It is her loss, but my privilege to attend this session.

I would just like to say that I regret not being able to remain with you and thus come to know more of you personally during the course of your stay in Washington. However, at this point, a new administration coming in, and the problems of the Department--the problems of trying to create a Department of what had been an Agency in the past--require that the Secretary and members of her staff concentrate pretty much on our own internal matters in the Department of Health, Education, and Welfare.

So I will look forward to the opportunity perhaps next year of spending more time with you, advising with you, coming to know you, and getting the benefits of your point of view on the problems we have in common. But I would like to say at this point what a privilege and pleasure it is to be in this great institution, to be associated with men and women like Dr. Eliot, Dr. Keefer, Dr. Scheele, and others in the Department, and with all of you who are devoting your time, energies, and thought to the welfare, wealth, and well-being of the peoples of our country. It is a very thrilling experience and a very exciting association.

Now I would like to run over some matters which I think are of mutual interest to all of us, and which I have here in a prepared statement for today.

Both your organization and these annual conferences are unique in several ways. They exemplify the most effective type of Federal-State partnership in action. Through this mechanism--established by the wisdom of Congress--you have developed a true forum for the free exchange of ideas and a unified attack upon numerous health problems. You have created an atmosphere of mutual respect and trust which permits frank and open discussion. This history of harmonious Federal-State relationships in public health has not come about by chance. It is the result of a half century of arduous work and firm determination to realize a common goal.

A review of the Proceedings of these Conferences over the period of years is most revealing--they are historic documents. Surgeon General Wyman in addressing the very first annual conference held under the law--in 1903--evidenced keen insight and a rare gift of prophesy when he said,

> "One of the most important features of this assemblage is its official character. All of us are familiar with conventions of similar purpose productive of much useful information, but entirely lacking in official significance. Here, however, are assembled the legalized health authorities of the States, representing the practical administrative experience as well as the theoretical and scientific knowledge required in the consideration of public health

affairs-- [This is] a most noteworthy event. For the first time in the history of the United States there has been placed in its statutes, by Act of Congress, a provision looking to harmonious and cooperative efforts in public health matters between the National government and the State governments."

I would just like to say parenthetically, most of you who have had experience abroad in health work know the basic difference where the Federal Government is entirely responsible for the health activities of the country. In this country we search for effective joint and cooperative effort. This relationship of Federal Government with States and counties is a tremendous challenge.

As a newcomer to this long standing and honorable partnership, I have less first hand knowledge than you of the specific and dramatic gains which have results in public health. My long association with the health activities of the Institute of Inter-American Affairs, however, has given me considerable experience in this field of public health. In traveling the highways and byways of Latin America, as the Institute program was developing, I have had a liberal education in the substantial results that can be accomplished through the joint efforts of a variety of organizations. So I share your pride in the progress which has been made here in the United States--progress which has been made possible only through the National and State governments working together as a well organized team, in full cooperation with local governments, with voluntary health agencies, and with the private physicians of each and every community of this broad land.

But remarkable as the public health accomplishments of the past fifty years have been, there still remain challenging problems to be solved.

Conditions which at present are the chief causes of sickness, disability, and death may prove more difficult to conquer than those problems to which public health workers first addressed their efforts--and which already have responded to public health measures.

Then, too, there are questions about the particular share of the cooperative job which each of the partners should rightfully assume in meeting today's health needs. What part can best be supplied by the States and localities? What contribution is the Federal Government best equipped to make--and under what circumstances?

One has only to scan the agenda of your Working Committees to see that these are matters of interest to you in the States, as they are to us here in Washington. It is for the purpose of considering such mutual problems as these--of looking forward rather than backward--that I regard this meeting today with the chief health authority of each State and Territory as a real opportunity.

First, it permits me to comment briefly on the significance of some of the major changes which have occurred in the Executive Branch of the Federal Government since your last Annual Conference. With a change in administration comes new leadership--and with new leaders come fresh points of view--perhaps even different goals.

President Eisenhower has a deep personal interest in the health programs of this country. He has abiding convictions concerning the dignity and worth of each individual member of our free society, and steadfastly believes that the individual can develop to his fullest capacity as a productive member of this society only if he enjoys good health--both physically and mentally.

The President's first move in reorganizing the Executive Branch was the proposal to lift the essential health, education, and social welfare functions of the Federal Government to Department status. This was accomplished by Congress on April 11 of this year.

For the first time in our national history, these social responsibilities--in the broadest meaning of the term--are represented at the highest council table of our government--the President's Cabinet. Health, education, and social welfare have become an integral part of the considerations of the President's official family.

And again referring to contacts abroad, people in foreign nations have often wondered how these vital functions for the people of this country who have been left out of the Cabinet can be delegated and relegated to agency status, rather than Cabinet status.

There are many facets of the new Department in which you would be interested. Time permits me to mention only a few organizational aspects before passing on to my main topic.

One step toward effective administration of the Department was the establishment by the Secretary of the Departmental Council. Together with the Secretary and other senior officials, the Council is composed of heads of the Public Health Service, Office of Education, Social Security Administration, Office of Vocational Rehabilitation, and Food and Drug Administration. An improved interchange of information and closer coordination of the Department's activities through the work of the Council are results already apparent.

The reorganization plan which established the Department provided the Secretary a deputy, the position of Under Secretary, which I have the honor to occupy, two Assistant Secretaries, and a Special Assistant for Health and Medical Affairs. In addition, the Secretary has several staff assistants. All these people make up a corps of associates to aid the Secretary in administering the Department.

The appointment of a Special Assistant--Dr. Chester Scott Keefer--to advise the Secretary on the Department's health programs and activities signifies the importance of health in our affairs. Dr. Keefer is concerned with the total health interests of the entire Department. One of his functions is to serve as liaison with the leading professional societies and voluntary organizations in the health field. His broad background in research and medical education will be extremely valuable to the Secretary and the Department in reviewing current programs and making plans for the future--plans in which your organization, working with the Public Health Service and Children's Bureau, will play a vital part.

The particular type of Federal-State partnership under which you work as public health officials has an outstanding characteristic--its responsiveness to change. This is inevitable.

Your programs are directly affected by--and must be closely geared to--many types of change: Changes in the public health problems you are called upon to solve; changes in the populations you serve; changes in broad national and international situations. These last, though not specifically matters of public health, have a strong impact upon the provision of health services.

Because State health officials are sensitive to the importance of and need for continuous evaluation of their programs--and because you are accustomed to periodically taking stock of your methods of doing business--you will agree, I think, that the beginning of a new administration is a logical time to examine carefully the road we have traveled. Possibly there is need to rechart the course ahead.

The Department of Health, Education, and Welfare is particularly concerned with critical evaluation of Federal participation in State health programs--both through grants-in-aid and through technical assistance.

Today, I shall limit my comments to grants-in-aid.

One of the basic objectives of the new administration is to achieve greater efficiency and economy throughout government. Not only Congress, but every Department and agency head of the Executive Branch has a strong determination to accomplish this purpose. The force of this broad and desirable objective is felt in the appraisal of all present and proposed activities. The first Presidential message to Congress emphasized that the number one order of business was elimination of the annual deficit. The sacrifices this will entail were clearly recognized. - - - (I quote)

> "This cannot be achieved merely by exhortation. It demands the concerted action of all those in responsible positions in the Government and the earnest cooperation of the Congress. Getting control of the budget requires also that State and local governments and interested groups of citizens restrain themselves in their demands upon the Congress." (Unquote)

Under this mandate, the Department is giving much thought to the complex question of Federal assistance to States and localities. First let me state that grants to health activities will continue. Most people freely acknowledge the necessity of government programs to protect and improve the public health. Indeed, public health services have become an established part of State and local government services.

The issue, then, is not whether a given function --

(Warning bell for Civil Defense drill.)

MR. ROCKEFELLER: I am afraid we are stopped by the bell.

(Laughter)

(Intermission of 15 minutes for drill)

DR. SCHEELE: Take your seats, please.

MR. ROCKEFELLER: Let's come to order, and we will proceed.

I would just like to say I couldn't help thinking when we were going down to the basement, of the terrific responsibility which you men and women who sit in this room will be carrying if, instead of this being a practice raid, there were a real raid on this country.

One of the things which deeply concerns the Secretary, and with which Dr. Scheele and various others in our Department are preoccupied, are the problems which the United States will face should the tragedy of a bombing occur.

And as one studies it, and I am sure that all of you who have State Civil Defense groups know, the problems are almost inconceivable that we are going to be up against as a nation. And as I say, I don't believe there is any group in the country assembled, who could more importantly carry that responsibility if it comes--and we all pray to God it won't--than you who are sitting in this room.

A possible raid has a very sobering and serious impact when one gets to thinking about it and we hope, as the coming year starts, to be able to more effectively than in the past work with you in devising and preparing for that eventuality which, as I say, we hope never comes.

One other thing, while we were talking downstairs--which relates to the part of my discussion at which I had arrived--is the question of funds. I hadn't included them in this talk, but I might just think out loud about them for a second. During the twenty-some years which I had the privilege of being on the Westchester County Board of Health, I had the opportunity of tracing the development of many of the programs with which all of you are familiar. Many of them were initiated during the period. One of the problems which we found in Westchester was the fact that the public took for granted many of these services, many they weren't even aware of--various types of inspection, board of control, and so forth. And we took on, just before the war, a job of trying to educate our own citizenry in Westchester as to what they were getting from their County Health Department service.

Such an educational job affected the appropriations which the Health Department received, or didn't receive, from the Board of Supervisors, and we felt--and I think rightly so--that you can't expect an intelligent citizenry to support programs which they don't know about, don't understand, or don't fully appreciate.

And it seems to me that is one of the responsibilities that all of us have, particularly in this period when funds are short, when budgets are strained, when taxes are high. The voter and the representatives of the people are bound to look--I was going to say "with jaundiced eye." That is not the expression to use here but rather, "with great care"--over the items that appear in budgets, and they are going to cut out those they feel are either less important, or one of those they don't understand.

It's a lot easier to cut out those you don't know about, because they don't have very much significance. I think that is something we, frankly, all have to keep in mind at this time.

Our citizens must fully appreciate the tremendous heritage they have in this country, and the tremendous asset in these basic health services which, too often, we found in Westchester were taken for granted.

Getting back to the question of grants-in-aid to which I was addressing myself. As I said, the public health services have become an established part of State and local government services. Perhaps, as I look, they have become established too well. They are almost, sometimes, overlooked, which is a serious thing.

Now, the issue, then, is not whether a given function should be dropped or continued, but how can it best be performed and supported. I believe that is the basic issue. It would be a happy solution if each separate function could be clearly allocated to one level of government or another. Then there would be no possibility of overlapping authority, duplication of effort, or conflict of points of view.

In reality, such clear-cut distinctions cannot be made. The States and the Federal Government are interdependent in the fight against health hazards which affect all States.

Since the people of the Nation move freely and frequently from one State to another--and it is a mark of both our freedom and unity that they can do so--and since disease ignores State boundaries, the health and productive capacity of the residents of one State are of interest and concern to all other States.

It is becoming increasingly clear that, in terms also of financial support, complete separation of the health functions of State and Federal governments is impossible. The kind of tax system under which our governments are now financed places much of the total tax-paying ability of the country in a limited number of States. Other States lack the resources to carry on, unaided, some of the most essential services. Bringing the problem to a head is the fact that in those States where the income is lowest, many of the needs for health services are greatest. Here the Nation as a whole has responsibility--particularly for strengthening those State and local public health services of national and interstate significance.

The Federal Government also has a vital role to play in encouraging the development of new programs and techniques designed to overcome major public health problems. When--through research and other scientific investigations--more effective methods become available for combating ever-changing health problems, assistance should be available--at least for a limited period of time--to assist the incorporation of these techniques into public health operations on a Nation-wide scale.

We believe, too, that it is appropriate for the Federal Government to provide special financial aid to unique projects which give promise of solution to special problems and to a limited number of areas with unusual health problems: Areas with exceptionally high incidence of disease; areas with concentrations of Federal activity, such as defense or military installations; areas with major interstate problems, such as health services for migratory labor groups; areas with "pilot plant" operations to develop knowledge or techniques for general application--to name a few.

Technical aid is also an important type of assistance with which the Federal agencies can continue to assist the States. The useful role of the Federal Government in the fields of health and welfare depends, to a considerable extent, on the quality and availability of its technical and professional services.

As we administer our grant-in-aid programs, we are aware of the dangers of centralization of control in the Federal Government. But these dangers can be averted if our Federal-State partnership is governed by one simple and historically sound motto, "Maximum opportunity for State decision, and minimum Federal control." As we continue our appraisal of grants-in-aid, we are carefully examining all our requirements in a soul-searching effort to abide by this watchword.

The need for rational solutions to fundamental problems of Federal aid to States was recognized by President Eisenhower early in his administration. He requested Congress to authorize the establishment of a Commission on Intergovernmental Relations to study and to make recommendations to him and the Congress on Federal-State responsibilities and fiscal relationships. In his message to Congress on the subject, the President said,

> "The Commission should suudy and investigate all the activities in which Federal aid is extended to State and local governments, whether there is justification for Federal aid in all these fields, and whether there is need for such aid in other fields. The whole question of Federal control of activities to which the Federal Government contributes must be thoroughly examined."

Organization of this Commission is now complete. The findings of this Commission will undoubtedly make a great contribution to our thinking and understanding of these relationships.

In closing, I would reiterate that the problems I have mentioned today are shared problems--important to the State and Federal groups alike. They are a continuing challenge to the cooperative approach you have taken to similar problems in the past. Keen imagination is called for all along the line if the entire country is to enjoy maximum health services at minimum expense. The good health of our people can never be taken for granted. Vision, vigor, and courage on the part of public health leaders are as necessary today as in the past.

But necessity has always been the spur to ingenuity. I am confident that there are many untapped resources and undevised methods for the provision of better health services. I am hopeful that in your work together here this week you may discover the key to some of them.

Thank you, very much.

(Applause)

DR. SCHEELE: Thank you, very much, Mr. Rockefeller.

I think you can see how fortunate we are in Public Health Service and the Department of Health, Education, and Welfare, to have a man who has had the broad background of experience and who has the interest in health problems that Mr. Rockefeller has.

I should say now, too, that our Secretary, Mrs. Hobby, has asked me to express her regrets that she could not be with you today. She hopes to be with you next year. It is unfortunate for our Secretary, too, because she has come into the Department with a broad interest in health problems. She has been on the Board of the American Cancer Society and on the Board of the Red Cross. She has

been very intimately associated with a number of major health programs in the State of Texas, especially in Houston. I find it very easy--and I am sure Dr. Eliot does too--in carrying on our part of the work in the Department--to be dealing with people who know what we are talking about. We haven't had to "educate" her.

I should like at this time to introduce Dr. Carl Neupert.

Carl, don't stand. Carl has a little pain, so it is difficult for him to stand.

Dr. Neupert is the Health Officer of the State of Wisconsin and President of the Association.

(Applause)

Next, I want to introduce to you who don't know him, Dr. Otis Anderson, Chief of our Bureau of State Services. Dr. Anderson.

(Applause)

DR. SCHEELE: The next person needs no introduction to you. She is Dr. Martha Eliot, Chief of the Children's Bureau, and I won't tell you about Dr. Eliot because you all know about her. Dr. Eliot can speak for herself, and she is the next speaker. Dr. Eliot.

(Applause)

ADDRESS

Martha M. Eliot, M. D. Chief,
Children's Bureau Social Security Administration
U. S. Department of Health, Education, and Welfare

It gives me a great deal of pleasure to meet with you again and to discuss with you our joint interest in the health of mothers and children. In some respects this has been a rather special year in the Children's Bureau; one of stock-taking and reviewing many aspects of our work.

We have been giving a good deal of thought to the principles basic to grants-in-aid and to the relationship of Federal grants to the development of State maternal and child health and crippled children's programs. We are asking ourselves and we are being asked such questions as, "What are the appropriate roles of the Federal Government in relation to the work of State health departments?", and "What effect, if any, have the Federal grants had on State and local appropriations for public health activities?" Such questions and others will, of course, continue to be studied by the administration and the Congress.

I would like to report to you some statistics which we have recently put together related to the maternal and child health programs. They show the growth of these programs in States and localities in the past 14 years, and illustrate what can happen when Federal, State and local governments combine their resources to meet child health needs. Let me tell you just what has happened.

In 1940, the State and local maternal and child health programs were financed by a budget of about 11.5 million dollars. Of this, 6 million were from State and local funds, 5.5 million from Federal funds. In 1954, the total amount budgeted is 40.5 million, or nearly four times as much as in 1940. The States today put up more than 30 million, the Federal Government 10.5 million. (See Chart 1).

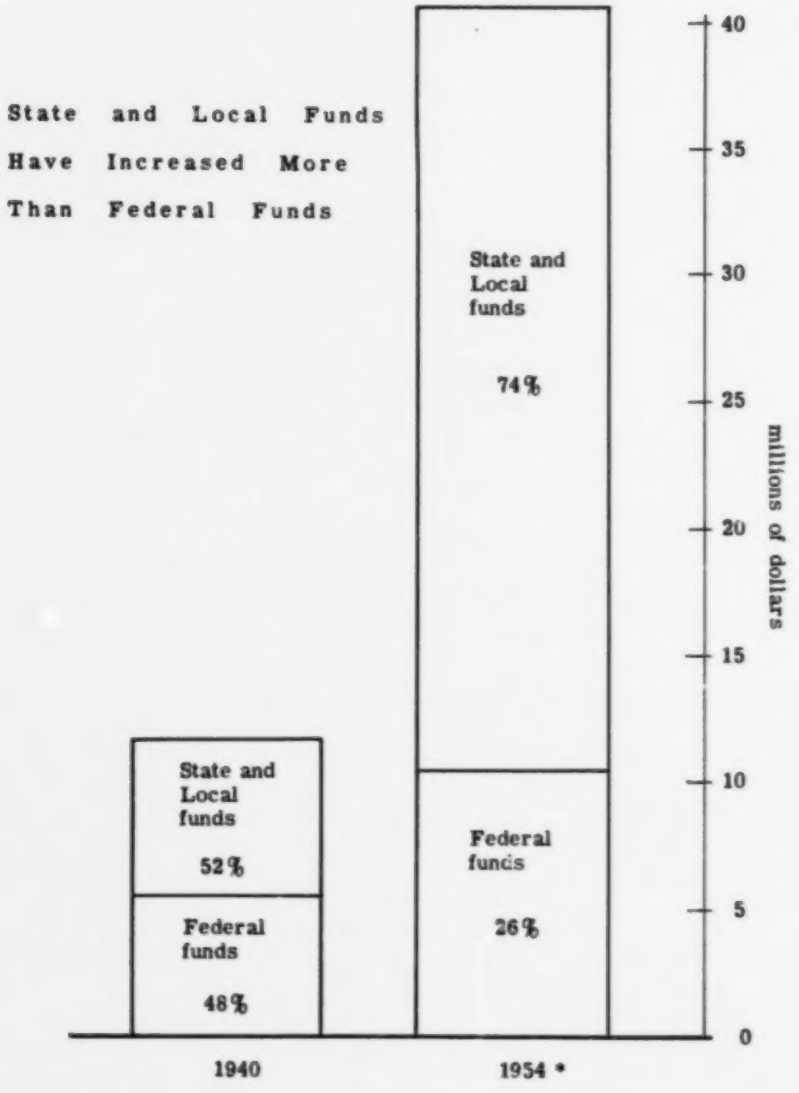
Clearly the expansion of State and local funds for child health has been much more rapid than that of Federal funds. From the beginning of this cooperative program the States have put up, in the aggregate, more than enough to match the required amount of Federal funds. By 1940, State and local funds were 37 percent in excess of the amount needed for matching. This year, 1954, 83 percent of the State and local funds is over and above what is required for matching. (See Chart 2).

We can contrast the contributions from Federal and State sources in still another way.

In 1940, the Federal contribution to the combined budget amounted to 48 percent of 11.5 million dollars. Today, 1954, the Federal contribution is only 26 percent of 40.5 million dollars. (See Chart 1).

The conclusion that we draw from this is that Federal grants have clearly served to draw out additional State and local funds. Similar data have been prepared on the crippled children's program and similar conclusions can be drawn here as in the maternal and child health program. (See Charts 3 and 4).

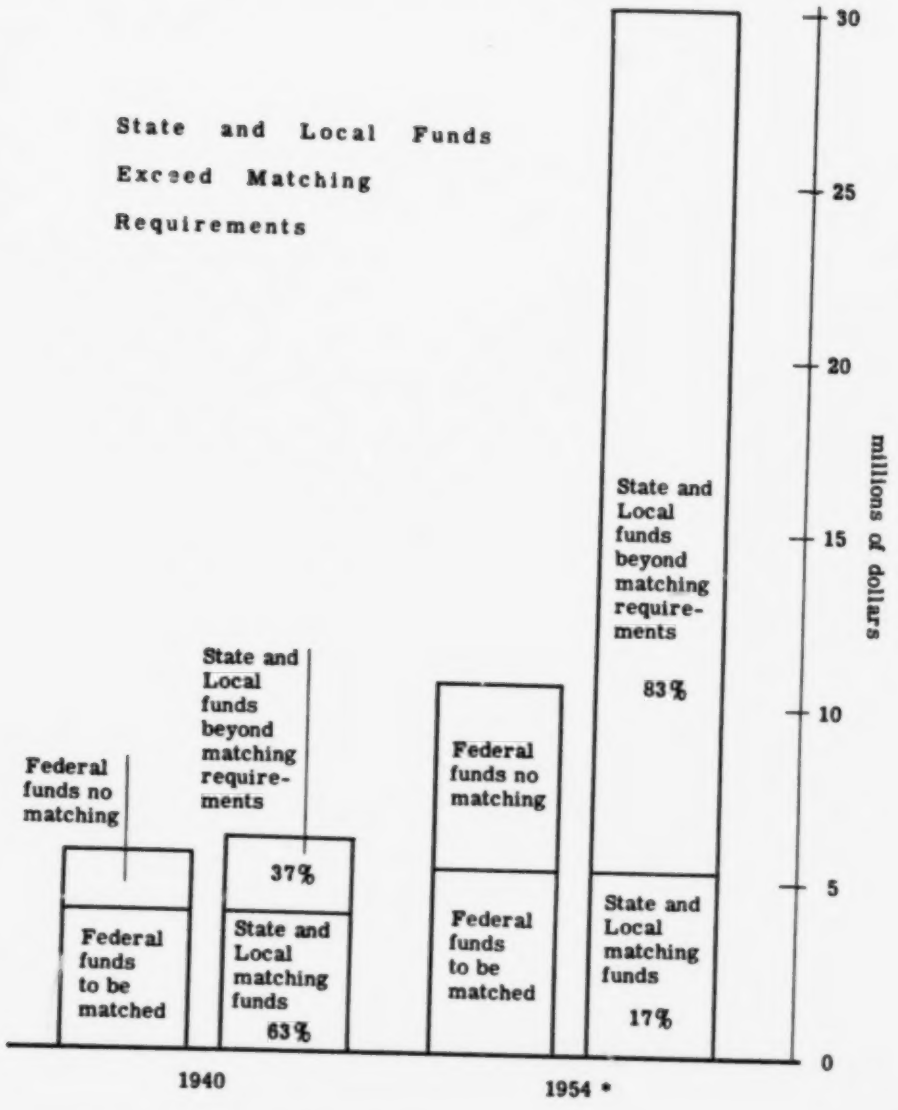
MATERNAL AND CHILD HEALTH PROGRAM



*reports not received from California, Connecticut, Massachusetts, New Hampshire, New York

CHART 1

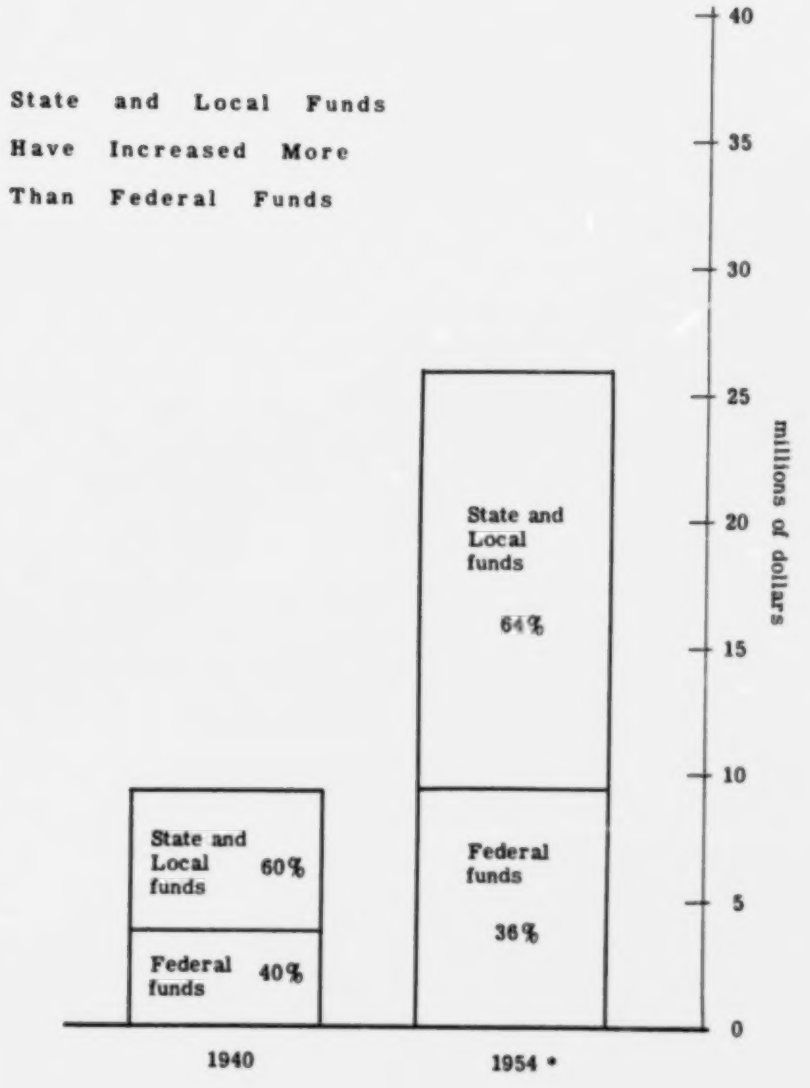
MATERNAL AND CHILD HEALTH PROGRAM



*reports not received from California, Connecticut, Massachusetts, New Hampshire, New York

CHART 2

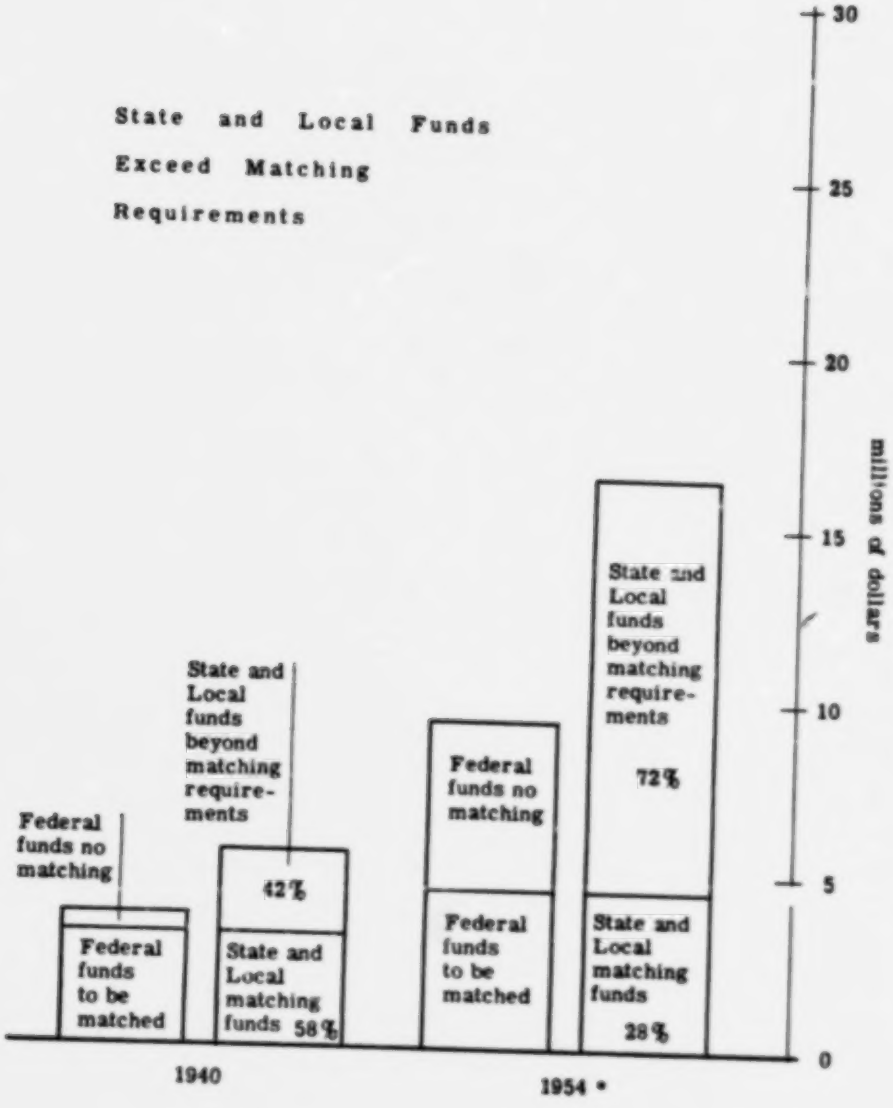
CRIPPLED CHILDREN'S PROGRAM



* reports not received from California, Illinois, Massachusetts, New York

CHART 3

CRIPPLED CHILDREN'S PROGRAM



*reports not received, California, Illinois, Massachusetts, New York

CHART 4

In the crippled children's programs the differences are not so striking since local funds play a less prominent role in this more highly centralized State program.

Of course these statistics represent totals of all States and do not, by themselves, bring out the considerable variations that exist from State to State with respect to fiscal ability. The fact that the fiscal capacity of the States vary, together with the fact that the poorer States have relatively more children, suggest that the Federal Government can help reduce the inequities in opportunity for children to receive needed health services. By distributing grants so as to help equalize the opportunities for health services within the Federal-State grants-in-aid programs, the Federal Government is making a significant contribution to children and recognizing that their health and welfare is of national concern and interest.

During these years State health departments and crippled children's agencies have used their funds with great imagination and insight. Let me give you an example. As infant mortality has declined and as the leading causes of death in infancy have changed, the health departments have increased their services to infants in the neonatal period, particularly those for prematurely born infants. The majority of the States are now assisting hospitals in improving their maternity and newborn infant services and facilities. They are loaning incubators to hospitals and local health departments. They are enabling nurses and physicians to receive additional training in the care of newborn and premature infants. Some are making special studies of prematurity. In many other types of activities, the States are emphasizing the importance of this aspect of the maternal and child health program. The medical and hospital care programs for premature infants which 16 States have developed are of particular interest. As a result of all these activities, greater attention is again being given to prenatal care, particularly for mothers with complications of pregnancy, in an effort to reduce the incidence of premature birth. A number of health departments are now studying the problems of fetal deaths as well.

Much progress has been made in the provision of health services for school-age children. Many of you can recall the dreary wholesale medical inspections which not so long ago constituted this program. We have broken away from tradition in school health services to a healthy degree. Emphasis is now on appropriate screening methods, especially for hearing and vision, on teacher observation and public health nurse consultation, on health education, and upon using the skills of the physician for examining selected children or those in a few selected grades, and for consultation. There is less emphasis today on whether it is properly the school's program or the health department's and more emphasis on the community's program for children, bringing together the public and private resources of the community.

During the first few years of the Social Security Act, the crippled children's program was virtually synonymous with orthopedics. Perhaps in the last few years we may have let the pendulum swing too far the other way with the result that not enough attention has been given to new developments in the orthopedic program. The progress that has been made in orthopedic services and in research in this field has been great, stimulated in part by the war. Of much current interest is the renewed attention being given to children who have limb amputations. The National Research Council has a Joint Committee on Artificial Limbs which is working with the Michigan Crippled Children's Program to develop a plan for making new types of prosthetic appliances available to children in the program.

I am reminded, too, that during the war great progress was made in the new science of audiology and in the development of new hearing aids. I think it quite probable that children have been more greatly benefited than adults by this research in audiology. We are looking forward to similar benefits for children from the research now in process on the structure of artificial limbs and braces.

But the crippled children's program is today more inclusive than orthopedics or plastic surgery. As the programs have broadened, the proportion of children with orthopedic conditions has declined. During 1952, about one-half of the 238,000 children receiving physicians' services in the crippled children's program had orthopedic diagnoses. The other half includes those having cerebral palsy, ear conditions, rheumatic fever, cleft palate, and other conditions requiring plastic surgery, eye conditions, epilepsy, and other neuromuscular conditions. The greatest relative increase in the past few years has been in the number of children with eye conditions, and children who have epilepsy.

One of the great contributions the crippled children's program has made to medicine and public health is the team concept in the care of children, particularly those who have long-term handicapping conditions. The recognition of the essential contribution made, not only by the physician, but by the nurse, the medical social worker, the nutritionist, physical and occupational therapist, constitute a landmark in interprofessional relationships. And closely associated with the staff of crippled children's programs are the staffs of the welfare, vocational rehabilitation and special education agencies. In fact, at certain times in the care of crippled children, these workers virtually become members of the team.

A few words about the increase in specialized personnel over the past decade or more will, I think, be of interest, particularly to those of you who have been associated with these programs for a long time.

In 1947 there were 20 specialized maternal and child health consultant nurses in health departments in 19 States; in 1952 there were 81 such consultants in 44 States.

At the beginning of the program in 1936, there were 9 nutritionists in 3 States' health departments; in 1953 there are 202 nutritionists in 46 States and Territories.

In 1936, only 2 departments employed medical social workers for their maternal and child health and crippled children's programs; today there are 375 medical social workers in 48 State health departments and crippled children's agencies.

In 1937, 3 State crippled children's agencies employed 5 physical therapists; in 1953 there are 147 in 40 States and Territories.

Much of this progress has been made possible by a remarkable growth in training programs and by changes in curricula in academic institutions. The schools of public health are all now offering courses in maternal and child health and some of them offer majors in maternal and child health. In addition to the many courses offered for the training of the specialists I have just mentioned, there are new training opportunities for workers in such specialized fields as audiology, prematurity, rheumatic fever, epilepsy, cerebral palsy, children's dentistry, many of which are supported by the States with funds

granted by the Children's Bureau. Most of these courses give particular emphasis to the community or public health aspects of these programs.

The influence of public health programs is also being felt in medical schools. A major development in the training of medical students which has significant potentialities for public health is the concept of "comprehensive medicine." This concept includes consideration of the patient as an individual who has family and community relationships which have a bearing on his health. Some of the schools are assigning a family to each student for his four years of medical training and he learns to serve as a family health advisor. These students are supervised by the faculty and are assisted in understanding the social and emotional components of health and illness by medical social workers. Community health facilities, such as prenatal clinics and child health conferences, are being used in this training plan. Such students will graduate with a far better understanding of public health and preventive medicine than the graduates of even a decade ago.

This is necessarily a very sketchy summary of some of the highlights of progress you have made in the maternal and child health and crippled children's programs. We can all of us be justifiably proud of this record, in which the facts speak for themselves. But there is no room here for complacency, or for a feeling that the job of protecting and promoting the health of mothers and children is just about done, or at least well on its way. We have, in fact, made an excellent beginning, but not much more than that. There is an enormous amount of unfinished business that lies before us.

Consider for example, some problems of infant mortality. A recent analysis of vital statistics tells us the neonatal mortality rate for full-term newborn infants is less than 8 per 1000 live births. But for premature infants the rate is 174 per 1000 live births or more than 20 times as great. It is easy to see why so much emphasis is being placed on prevention of prematurity. As impressive as the decline in infant mortality has been, we must keep in mind that 10,000 infants could be saved each year if all counties had rates as low as those with cities of 50,000 population or more. This illustrates again the need for our maintaining a special interest in children in rural as well as urban areas. The disparity in maternal mortality between high and low income States is excessive, being 5.9 per 10,000 live births for the former, and 1.3 for the latter. Whereas for the United States as a whole, 5 percent of births in 1950 were unattended by a physician; 15 percent of the births in the low income States took place without a physician.

The major problem in the maternal and child health program, prematurity, looms larger as we find out more about it. In about half of the mothers who have premature infants, the cause is obscure. But we do know that mothers in poor social and economic circumstances are more likely to go into labor prematurely than others. The average duration of hospital care for a baby in premature centers is about 30 days and the average cost of hospital care in voluntary hospitals is about $19 a day. Prematurity is, therefore, a very costly business. Only an occasional hospital insurance plan provides for the newborn infant. Undoubtedly early hospitalization of mothers who have complications of pregnancy, as is advocated by Taylor at the University of Colorado and others, does prolong gestation and reduce prematurity, but few States are providing such care even for mothers lacking other resources.

In the crippled children's program, services for children with other than orthopedic handicaps are being provided for the most part in demonstration programs which have a sharply limited geographic basis. The orthopedically crippled are not the most numerous among children who are handicapped. Yet about one-half the children who receive physicians' services are orthopedically handicapped. It is usually estimated that children who have rheumatic fever are as numerous, and there are more who have serious hearing or visual impairment. Twenty-eight States have rheumatic fever programs, for the most part demonstrations, which together provide services for only about 10,000 children a year. Services for children with other less visible handicaps are just as limited or more so. Yet they may be just as crippling as the more obvious orthopedic handicap. The job that lies before us is the translation of these well-established demonstration programs into service programs with the same geographic coverage as the orthopedic services.

The problems hindering such a development are chiefly financial. We have to contend not only with the added costs of extending or developing such programs, but also with the increasing population and the increasing costs of living. There were in 1952, 50 million children under 18 years. This child population increased 25 percent between 1940 and 1952. Costs have increased too. Hospital expenses per patient day went up 118 percent between 1945 and 1952, and close to half the expenditures in the crippled children's program are for hospital care. In the same period salaries for county public health nurses rose 60 percent and salaries of medical personnel, 52 percent. Yet, I am convinced that together we will gradually go ahead and find the ways to meet these problems and provide the services our children need. We cannot afford not to do so. The cost of neglect is too great, not only in terms of human values, but of money as well.

I have discussed thus far only some of the problems of the maternal and child health and crippled children's programs. But there are others just as pressing in which health departments and crippled children's agencies have as yet been involved only to a slight degree. I am referring to the serious situation which faces us with regard to children who are delinquent, children who are mentally retarded, and the children of migratory agricultural workers.

I am sure that all of you have been hearing and reading much about the reported increase in juvenile delinquency and I am also sure that many of you have been actively working in your States and communities trying to do something about this situation.

Juvenile delinquency is not the product of any one social or personal factor, but of many. You and I know that the child's own personality, the effect of his family relationships and cultural patterns, the neighborhood in which he is raised, the economic situation, the tensions of the times, the lack of an appealing school program, various forms of discrimination, bad housing, broken homes, all these contribute to the making of a juvenile delinquent. To reduce the number of delinquent children will require great extension and improvement in many of our social institutions, and a major change in the economic and social situation in many well-defined urban neighborhoods. Health agencies have a real role to play--in preventive maternal and child health services.

Each year the Bureau receives many requests for help with problems growing out of mental retardation in children. Groups in local communities, and professional workers, are becoming more outspoken about what they want for mentally retarded children and are taking leadership in attempts to get better facilities, training, and treatment programs for these children.

Of particular interest to all of us is the period of infancy and the preschool years when parents begin to realize that they have a retarded child. The family physician is usually the one who has the responsibility of informing the parents that they have a retarded child. This is a critical occasion, one which most physicians would rather not face. How it is done is important. The physician frequently needs psychological assistance in reaching a diagnosis. This problem is seen of course in your child health conferences. The parents need a great deal of help in coping with such a situation. The Children's Bureau hopes to be able to make available to you some consultation service in this field in the not too far future.

The problem of the migrant agricultural worker has been with us for a good many years now and I know many of you have struggled with it. One of the major blocks to picking up on this responsibility seems to be a feeling of helplessness in doing it alone. A number of health officers have indicated the willingness of the States to do their share but have expressed their feeling of bafflement about how to deal with a group of people, present in the locality for only a few weeks or months, who receive little or no care before coming and little or none in the places to which they go. If a group of States could get together on a coordinated plan, with the State of origin doing its part and the States along the migratory route picking up theirs, all of the States would be helping one another. We believe such a plan is possible and will be wanting to talk with some of you, particularly those from the States on the Eastern Seaboard, about your interest in such a project. To you who know the problem so well I need hardly add that welfare and education, along with health, must be intimately involved.

In working out some of these problems, particularly those involving several State agencies, many States have found it helpful to organize State Committees on Children and Youth. Similarly, the Children's Bureau participates in the Interdepartmental Committee on Children and Youth. This Federal Committee has 30 members, representing Government Departments, Agencies, and Bureaus whose work in some way relates to children and youth. Many of you, or your staff, are members of State Committees on Children and Youth. In most of the State Committees, the lay participation has been especially helpful in getting citizen support. The Federal Interdepartmental Committee has just entered into an agreement with the organization to which these State Committees belong--The National Advisory Council on State and Local Action for Children and Youth. The agreement makes provision for an exchange of information about what is going on in the various States and between the States and the Federal agencies. We believe this will be beneficial both to State Committees and to the Federal agencies. We believe it will further all our objectives.

You can see that I am greatly impressed with the progress that has been made in the programs for children and that I am equally impressed with the magnitude of the job that lies before us. I am confident that just as we have come this far together, so will we continue this highly satisfactory method of working together and continue to extend and improve services for mothers and children. Literally millions of children are depending on us.

ADDRESS

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Surgeon General, Public Health Service
U. S. Department of Health, Education, and Welfare

I am sure that this Conference of the Public Health Service and the Children's Bureau with the States and Territories will go down in history as a momentous one. Doctor Eliot has mentioned landmarks along the path of maternal and child health, and I should like to mention a few landmarks too. One is that referred to by Mr. Rockefeller. For the first time, the many governmental activities which concern you and us directly or indirectly have been brought together in an Executive Department of the Federal Government. For the first time, our mutual aspirations for the health of people everywhere, and our mutual problems are represented in the President's Cabinet by our first Secretary of Health, Education, and Welfare.

The completion and operation of the Clinical Center of the U. S. Public Health Service set another landmark in public health since last we met. I would predict that the nationwide research effort in which the Center is destined to be a dynamic force, will produce sooner than we think, findings capable of turning public health work upside down. The great revolutionary findings of the nineteenth century in the field of bacteriology and related disciplines brought public health into being as a scientific profession, and those same findings revolutionized the practice of medicine. Medical research is on the verge of remarkable advances in our knowledge of chronic diseases, viral diseases, and mental diseases, as well as in our basic understanding of the human organism and its functioning.

I predict that the new findings will give preventive medicine a greater force in the medical arts and sciences than it has ever had in the past. At the same time, the new findings will turn public health practice as we know it today--upside down. Our role of supporting clinical practice will take on new significance.

I am glad that this session of the Conference will be followed by a tour of the Clinical Center. You will see many interesting new features in the physical plant, as well as many challenging research studies. Each project is designed to throw new light on some facet of diseases which are killing or disabling large numbers of people everywhere. The studies on metabolic balance in rheumatoid arthritis, on hypertension, on hormone-producing tumors, may seem remote from the activities of a public health department. The end-results, however, may be of immediate concern to you and your staffs.

The mass cripplers and killers must ultimately be prevented by simple methods. Some may criticize this concept, but I insist that this is the goal of research and of medicine. Let us take, for example, certain common forms of arteriosclerosis:

If we find that certain alterations in metabolism lead to arteriosclerosis,--as studies reported by the National Heart Institute suggest--, and if we can then

find a chemical means of blocking such metabolic dysfunction, we may have a preventive technique as important to medical and public health practice as was the discovery of Vitamin C in the prevention of scurvy and of Vitamin D in the prevention of rickets. This may seem like a dream--but I believe we are on the threshold here at the Clinical Center and elsewhere in the United States of just such important discoveries.

We may also find methods capable of mass application for the prevention of some non-infectious diseases. Who would have thought, in 1943, for example, that a technique for treating the water supply to control a non-infectious disease would be discovered, developed, and put to work in nearly 800 American communities within a decade? I refer, of course, to the fluoridation of public water supplies for the reduction of dental caries in children. During the past year, the eighth annual examination of school children in Grand Rapids--where fluoridation was first applied--showed the same excellent results of past years.

The significance of the fluoridation story is this: By a single method we are able to combat a non-communicable disease that currently costs the Nation at least half a billion dollars annually in dental bills--plus untold amounts in lost-time and in the ill-effects of dental decay on personal health. The fluoridation of public water supplies does not prevent all caries, but it will eliminate a major segment of the problem. A goal of public health in communicable disease control has been at least to reduce a specific infection to manageable proportions. We are now learning how to accomplish the same goal in non-communicable diseases.

It is not only possible, but probable that the greatly intensified research program throughout our Nation will produce new, simple, and relatively inexpensive methods for community-wide attacks on far more serious diseases than dental decay. The work on environmental factors in the causation of cancer, for example, may one of these days produce the evidence and the methods we need for a forthright attack on cancerigenic agents in the environment. By this means, we might directly prevent the occurrence of a significant number of cancer cases.

We sometimes find it difficult to realize that the broad principles of prevention--environmental control and preventive therapy--may be just as applicable to the chronic diseases, mental illness, and traumatic causes of death and disability, as to dysentery, diphtheria, and whooping cough. At a recent staff meeting in the Public Health Service, we heard that a case of hoof and mouth disease had been reported from one of the States. All the machinery of diagnosis, confirmation, and search for the source of infection had, very properly, been set in motion. Eventually, the resources of other State health departments, the Public Health Service, and Federal-State departments of agriculture also will be drawn into the search and control effort.

I could not help remembering that every day, nearly 2,000 people in the United States die of cardiovascular diseases; 575 others die of cancer; and 240 more die in accidents. Yet the combined daily loss of some 2,800 lives from these three major causes alone all too often creates no such surge of concern and action as does the occurrence of a few cases of a rare infectious disease.

Actually, some of the available methods for the control of chronic diseases are far less crude and costly than are the available methods for preventing the spread of hoof and mouth disease. The prevention of rheumatic fever--especially of its cardiac sequelae--is a case in point. The preventive therapy now available

with sulfa drugs and antibiotics is certainly more effective and less expensive than earlier methods of controlling scarlet fever, for example. The channels for its application are the very ones that public health officers and private physicians together opened for the application of immunization against diphtheria, smallpox, and typhoid fever 50 years ago; and again for the diagnosis and treatment of syphilis 35 years ago.

The precise techniques and the division of labor in the control of chronic diseases may be different. The channels of cooperation between the health agency and the practicing physicians, and between them and the voluntary agencies, the hospitals, the schools, and other community facilities, however, are the same. And it is the foremost challenge to the State and local health departments to pick up the spade and do the ground-breaking in opening up these channels of cooperation.

The health officer and his staff cannot take over the practice of medicine, nor is it their desire to do so. Ours is the challenge, however, to work with our colleagues in private practice, in medical organizations and specialty societies, so that a higher level of national health can be attained. Cooperation and teamwork for health should be the watchwords of all members of the health professions, regardless of the setting in which they work. Learning how to cooperate is one of the great problems before us and the extent to which we seriously explore and develop techniques of cooperation will be the real measure of our fulfillment of the trust we hold. This is true for all of us--whether we be general practitioners, specialists in private practice, hospital administrators, dentists, nurses, or public health administrators.

There should be no conflict of interests. Rather there should be harmony of interest. This assignment calls for developing our skills in the art of cooperation to the highest possible degree. It calls for imagination, persistence, and patience. All of the health professions need especially to bring to bear creative thinking on how to go about developing cooperative action for the prevention of chronic disease. We in public health and our colleagues in private practice have grown up professionally with certain established patterns of organization and operation.

The problems which confront us today cannot be solved in an identical framework in all communities. Perhaps what we need most at the present time is some communities with bold thinkers who will dare to conceive and test new patterns of organization and operation for the control of chronic disease. The communities that can come forward with such thinking may well be the pace-setters for future progress in public health.

Federal-State relations

Consideration of the Nation's major health problems invites consideration of the future relations of the Public Health Service with the State and Territorial Health Officers and their staffs, the Hospital and the Mental Health Authorities. The issue of Federal financial grants to the States in all fields is receiving the most serious attention at the highest levels of our Government, as Mr. Rockefeller has pointed out. He described the Commission on Governmental Functions and Fiscal Resources, established by Congress last May. The Department of Health, Education, and Welfare also has set up a special intradepartmental task force to cooperate with the staff of the Commission. All of us are working to the end that

the President's aim may be reached: namely, that the programs "be made more effective instruments serving the security and welfare of our citizens".

The question of financial grants is only one of many to be considered by the Commission. However, it is certainly one of transcendent importance to the States and communities who will have to make the final decisions as to whether the services now supported in part by Federal grants are to be continued and maintained at effective levels. Mrs. Hobby has expressed several times the policy of this Department on Federal grants, and Mr. Rockefeller has presented it to you today.

If the Nation's health authorities will reflect on these developments, they will find that it requires a fresh look at the purpose of Federal grants and at the means for implementing health programs in the States and local communities. The tendency in the past has been to expect the continuation of a given grant program, whatever its category,--general health, maternal and child health, venereal disease control, and so on. More and more the States should try to provide funds to cover programs once aided by Federal grants. This will free Federal funds for new programs.

Many of the State health officers will recall that Congress developed the very first "categorical grant" program--venereal disease control--on the principle of increasing State responsibility. The war period and the subsequent addition of other categorical programs have tended somewhat to obscure that principle. Many officials in public health, hospital construction, and mental health programs have not realized that the time would come when definite program appraisal and planning for the assumption of financial responsibility would be in order.

Our cooperative venereal disease control activity provides an example of what can be done to keep a categorical program dynamic--moving toward the goal for which it was created. In 1938, the Nation's health and medical authorities assured Congress that it was possible to bring venereal disease under control throughout the United States in a generation, or about 25 years. World War II with its accompanying increased spread of venereal infections would have set back the schedule many years had it not been for two fortunate situations: first, the swift action on the part of Federal, State, and local health agencies to set up a going program; and second, the advent of penicillin, which climaxed many years of research.

The States and the Public Health Service have never lost sight of the original goal. When the project grant program was initiated, State and Federal staffs jointly worked out a time-table for bringing VD under control in each State. Twenty-four States had attained their goal by the close of the fiscal year 1953.

The time-table calls for control in the remaining States by the close of specific years, up through 1963. The Public Health Service and the Armed Services hope to provide continuing resources for handling the venereal disease problem in areas where direct Federal responsibility is clearly indicated. After 1963--the target year for control of venereal disease throughout the United States--the Federal Government's responsibility should be limited to surveillance against the interstate spread of disease, as in other infections under control.

This goal can be reached--but only if the States pick up their share of the burden. It will be a tragedy--nay, a disgrace--if after so many years of

successful cooperative effort, after the pledge of public health to the Nation to control venereal disease, we do not attain this goal.

It may be that we cannot at the present time "pinpoint" the attainment of other public health goals with the precision we have achieved in venereal disease control. But the States and the Public Health Service should make it their joint concern and persistent effort. Your responsibility and ours is to render an account to the public of what we expect to accomplish, how we expect to attain the goals, and when. We need clear delineation of Federal and State responsibilities, including delineation of the need for Federal financial aid and State support.

All of us realize that the combined current expenditures--Federal, State, local, and voluntary--for public health work in the United States falls far short of the amount needed to provide health services which will give the people the full advantages of modern medical and public health science. In looking ahead, therefore, we must go beyond the static concept of maintaining State and local services at the current level. The public health, hospital construction, and mental health authorities will need to make it clear to their legislatures and their citizens that a mere replacement of reductions in Federal health grants will not be enough. More than replacement is needed if the American people are to attain higher levels of health in the future.

Additional expenditures of themselves, however, do not ensure progress. Of equal importance is a more effective use of funds. Last year, I emphasized the need for a comprehensive appraisal of current public health practices, with a view to providing more effective local health services.

Many States and communities have inventoried their resources and activities from time to time; but few have measured the results of specific practices and procedures. Only by careful observation and study of local programs in various community settings will it be possible to develop reliable criteria for the improvement of current practices. Only through such studies can we test the comparable effectiveness of new and old procedures.

The Public Health Service has made tentative plans for such a study, and it is gratifying that some States and communities are preparing to inventory their programs in terms of current needs and to appraise their administrative practices. The data from these new-type inventories will be useful in connection with our study of public health practices. A complete stock-taking of Public Health Service activities and operations in the Federal-State cooperative programs also is under way. As we anticipated, the job is not easy. Our guideline is: How to get more for each tax dollar in a reduced budget, without sacrificing quality of service.

The new Hoover Commission--the Commission on Organization of the Executive Branch of the Federal Government--is a second high policy-level group that will be concerned with health programs and organization. The Commission will have 8 task forces, including the following of special interest to you and the Public Health Service: water and power resources; Government medical services; personnel and Civil Service; and accounting and budget procedures. Mr. Hoover has appointed Mr. Chauncey McCormick of Chicago as Chairman of the Government Medical Services Task Force.

The scope of the second Hoover Commission's mandate is considerably wider than that of the first. The first Commission was restricted to proposals for

reorganization and realignment of existing functions. The second is authorized to recommend abolishment of functions and activities not considered necessary to the Government, and the elimination of non-essential services, functions, and activities which compete with private enterprise. It may also recommend specific legislation.

Mr. Hoover has set December 31, 1954, as a target date for completion of the Commission's legislative recommendations. Some of these may be ready early in 1954, however.

Water resources and pollution control

The proposals of the Commission on water resources will be of special interest to health officials. The critical situation which now faces the entire country is familiar to all of you. In a special message to Congress, July 31, the President emphasized the need for a sound national program of conservation, improvement, wise use, and development of both land and water resources. He also stated his belief that such a program can be achieved through cooperation among the States, local communities, private citizens, and the Federal Government.

The States have made impressive advances in water pollution control in the past five years, but even greater accomplishments are needed if the Nation is to keep pace with the demands of increasing population and industrial production. By far the largest and most serious pollution problem is that of industrial wastes. We do not yet know the precise effects of chemicals in water on human health. We have not yet developed sufficient methods for eliminating these waste products. The production and use of chemicals--new and old--have vastly increased in recent years. The Nation's health authorities are in a position to aid water conservation programs, as well as the control of pollution, by increasing their vigilance over water uses and practices which impair the basic sources of supply and at the same time are potential hazards to public health.

Radiation problems

We are making progress in the study of radiation problems. Two State health departments--California and New Jersey--in particular are going forward with pilot programs for the control of radiation hazards. Several cooperative programs have been established between the Atomic Energy Commission and the Public Health Service. The Service has recently had a special team which maintained liaison with the Atomic Test Group and the States. A public health team has done a most creditable job this year in monitoring fall-out of atomic debris in areas up to 200 miles from the test site.

Home accident prevention

I am especially pleased to report progress in yet another "new" public health program--home accident prevention. The W. K. Kellogg Foundation has awarded grants to 8 States for the conduct of State-wide demonstrations in this field, on recommendations of the Public Health Service. The Foundation based its extension of support on the success of the four local demonstrations initiated two years ago. The Service will cooperate with the States in their demonstrations, as we have in the local projects.

The Public Health Service has been fostering this interest in home accident prevention for the past three years. We have been able to assemble an enthusiastic and well-qualified team to assist in the design and conduct of demonstrations. The activity is giving our organization and State and local health departments valuable experience in how to develop needed new programs through cooperation with voluntary agencies, private foundations, and universities.

The Public Health Service has been the catalyst and technical consultant. The States and communities participating in the program have recognized a need and want to do something about it. A private foundation has provided the funds for finding out how to do the job. The National Safety Council has been an active participant and a valuable spearhead. The University of Michigan School of Public Health has played host to the first National Conference on Home Accident Prevention, sponsored by the Council and the Public Health Service, last January. Perhaps this is a design for public health progress in some other areas--and a role that the Service should play in other new and challenging fields in the years ahead.

Highway accidents also maim hundreds of people and take a major toll in lives every day. Voluntary and official agencies are deeply concerned with this problem, yet few official health agencies serve as consultants to the interested groups, or play any role in helping stem the tide of accidents. Technical advice on physical standards for drivers' licenses and on safety engineering is a fertile field for health department cooperation.

Other environmental programs

For the first time, the Public Health Service has a small sum allocated in the 1954 appropriations for assisting the States in the certification of interstate milk shippers. During the past two years, 395 shippers, representing 30,000 producers in 33 States and the District of Columbia, have been certified by the States. A year from now we expect that approximately 600 shippers, representing 50,000 producers, will be participating in this program.

Work has been completed on the first section of the Poultry Ordinance and Code, which we have been developing with the States and representatives of the poultry and poultry-products industries. The industries are concerned, as we health workers are, that about one-fourth of all reported outbreaks of "food poisoning" are traced to poultry and poultry products. This fact tends to cause some communities to adopt regulations that serve, in effect, as trade barriers--but not always as adequate protection for the public. A guide to regulations that will both safeguard public health and permit the widest possible distribution of essential foods should be a good springboard for improvement in this area.

Emergency activities

One of the most important events of the past year was the adoption of a formal agreement by the Public Health Service and the American Red Cross regarding cooperation in time of disaster. A copy of the agreement was forwarded to you with the agenda of this Conference and will be a subject of further discussion tomorrow. The Service and the Red Cross recognize that really effective handling of disaster problems can be accomplished only by the State and local people. The State health officers can do more than any other single group to promote such effective handling of disasters in their jurisdictions.

I wish to commend the State and Territorial Health Officers--each and every one--for the highly successful operation of the emergency gamma globulin distribution program this summer. Between May 15 and October 1, nearly 3 and three-quarters million cc of gamma globulin for polio were allocated to the States under policies established by the Officer of Defense Mobilization, on recommendation of the National Research Council, the Association of State and Territorial Health Officers, and other national groups and individuals. Mass prophylaxis programs, requiring more than 1.6 million cc of gamma globulin, were conducted in 23 local communities in the continental United States and in Juneau, Alaska. Approximately 231,000 children were inoculated in the mass programs.

Whatever epidemiologic investigation and scientific appraisal may indicate regarding the effectiveness of gamma globulin in the control of paralytic poliomyelitis, we can feel real gratification that national, State, and local agencies have demonstrated their ability to apply new operating procedures to a traditional public health problem--epidemic control.

In the gamma globulin program, the health officer found himself in a position opposite to his usual role. He had to restrict the use of the material rather than devote his efforts to the promotion of increased application of a public health measure. Despite the difficult, controversial, and potentially unpopular nature of the assignment, no health officer declined to take the responsibility. The Public Health Service's Civilian Requirements staff functioned effectively in meeting the requirements of the States. There was marked improvement in the reporting procedures.

Our success in jointly conducting such a "different" nation-wide activity has proved again that Federal-State-voluntary cooperation in the health field is strong, reliable, and able to take new responsibilities in stride. The National Foundation for Infantile Paralysis is now asking your cooperation in large-scale testing of a killed-virus anti-poliomyelitis vaccine. If studies to date are confirmed in a larger test series, the vaccine may provide an effective immunizing agent which will eliminate large-scale use of gamma globulin against paralytic polio.

Health of migrant workers

There are plenty of unresolved problems on our doorstep that need joint action among ourselves and with our colleagues in related fields, such as education, welfare, vocational rehabilitation, law enforcement, agriculture, and others. We need the help of our colleagues especially in solving such problems as health services for migrant workers. Doctor Eliot has discussed this problem with you. She and I are particularly gratified at the interest and constructive thinking demonstrated by a number of State health officers with respect to migrant health.

Hospital construction problems

You will recall that, in the approval of projects under the Hospital Survey and Construction Act, the so-called "split project" technique has been utilized for several years. The technique was designed to permit the approval of large projects, which because of their high cost, would absorb all of a given State's annual allotment, or even exceed it. By spreading the Federal participation over successive fiscal years, it was believed that such projects could be financed without jeopardizing the intended initiation of new construction throughout the country.

At the last session of Congress, there was adverse comment regarding the "split project" technique. As a result, with the approval of the Secretary, the Public Health Service is issuing a revised "split project" policy. The effect of the revision will be to limit the approval of such projects to sums not to exceed two-thirds of the equivalent of the Federal appropriation for 1954 in the fiscal year 1955, and to one-third of the same in 1956. In addition, applicants for "split projects" will hereafter be required to demonstrate their ability to complete a usuable facility in the event of reductions in, or failure of, Federal appropriations. Members of the Public Health Service are discussing this new policy with State health and hospital authorities during this meeting.

Personnel problems

Personnel shortages continue acute in many categories. I regret to say that the shortage of medical public health administrators has grown more critical during the past year. Clinical practice continues to attract most young physicians. I hope that our colleagues in private practice and in the medical associations will increasingly recognize the serious problem which faces public health and that they will join us in an aggressive campaign to fill some of the gaps.

In the fields of sanitary engineering and nursing resources, several interesting projects have been completed. They will be useful in helping meet some of the shortages in these categories. The Public Health Service, for example, has completed a study designed to discover why such a high proportion of the sanitary engineers leave the field for which they were trained in college. It now appears that the majority of these men came into sanitary engineering a good many years after graduation, instead of at the outset of their careers. We hope that some way will be found to inform the college seniors of all the jobs now available to them in sanitary engineering--preferably by the middle of the senior year.

The American Hospital Association, The National League for Nursing, and the Public Health Service have prepared a manual of simple nursing procedures for the training of nursing aides. Originally, the Health Resources Advisory Committee of the Office of Defense Mobilization urged the Service to investigate the need for training of these hospital workers. As you know, there are more than 200,000 auxiliary nursing personnel employed in the Nation's hospitals. Most of them have had no preparation. The "learn-as-you-go" training they get is time-consuming, as is the constant supervision they require from professional nurses.

The new "Handbook for Nursing Aides in Hospitals" will be off the press about December 1. At that time, the National League for Nursing will begin a series of regional institutes to teach key nurses in local areas how to use the handbook and to apply the methods of instructing nursing aides which it introduces. I hope that the State health officers and hospital authorities will help extend the training of nursing aides by sending one or more of your nursing consultants to the regional institutes when they are announced in your areas.

The need for health manpower in the United States technical assistance programs overseas also continues to be acute. President Eisenhower has emphasized the importance of these programs, and we call on all of you to rotate some of your staff through tours of duty in international health services.

Last year, we solicited your cooperation in having State health departments sponsor health missions overseas. We realized that there would be many legal and

regulatory difficulties to overcome, so we are pleased that three States have taken definite action.

We also wish to express our gratitude, and that of our colleagues overseas, for the splendid work the State health officers, their staffs, and local health authorities have done this year for the thousands of foreign students and visitors in our country. You have contributed immeasurably to our Nation's foreign relations by your warm and continuing interest in these neighbors from the free world who come to study and observe our American health services. I assure you that your understanding and friendship are sincerely appreciated by the men and women whom you have helped.

Conclusion

I am sure that many public health workers in the States and territories, as well as in the Federal services, are wondering how they can make the admittedly inadequate Nation-wide expenditure for health purposes do a bigger job and a better job--in the face of rising costs, some reductions in financial support, and continuing personnel shortages.

I am sure that we can do a bigger job in spite of some adversity, and I believe that all of us can do a better job. The people in our States and communities must learn to look to their State and local governments and their voluntary agencies for additional support of the services which reach them directly. All of us must learn how to be more efficient in the utilization of available funds. We all need to do a little soul searching. Critical appraisal of our practices and projects may well reveal economies that will make it possible to do a better job in our traditional public health activities, as well as to start some new programs. It will help us eliminate repetition of long-outmoded programs and practices. In so doing, we will be able to launch a successful attack on the major causes of ill health; an attack planned and carried out in an atmosphere of full cooperation and trust by all professional groups, official and voluntary--and without official control and dictation. Such an attack will bring us closer to our great goal--higher levels of health for the American people in their communities.

(Applause)

(Announcements)

(Whereupon, at 11:50 a.m., the meeting was adjourned.)

GENERAL SESSION, NOVEMBER 7, 1953

With The

PUBLIC HEALTH SERVICE and the CHILDREN'S BUREAU

(Dr. Leonard A. Scheele, Surgeon General, Public Health Service, presiding.)

DR. SCHEELE: The meeting will please come to order.

Apparently, we have a quorum. I am sorry we had bad weather for you yesterday, but the sun is shining today.

From all reports, you apparently have labored hard. Some of us who have watched from a distance have a feeling that the meeting has gone as smoothly, and even more smoothly probably, than some meetings have gone in the past.

We are all aware of the fact that you have worked hard at taking a sort of new look at the Federal-State relations in the program and the problems, and I want to say how grateful we are that you have been here.

Dr. Neupert, I understand you have some reports for us. Why don't you stay there and we will come over.

DR. NEUPERT: Dr. Scheele, it is my privilege to present to you our work of the past few days in the form of resolutions, recommendations, and so forth.

Also, I would like to say, Dr. Scheele and Dr. Eliot, we have appreciated more than we can tell you the tremendous help given by you and your staff in working out, organizing, and consulting with us, thus making our meetings here so meaningful and so constructive. We feel it is a privilege to be here.

DR. SCHEELE: Thank you, very much.

I think in keeping with the pattern that we set a year or two ago, we will not go over the individual reports and attempt at this time to give you hasty comments on each of your suggestions and remarks but, instead, we will study them carefully and in due time will make a report to you.

I believe that the idea of having your Executive Committee meet with members of our staff is necessary in the course of the year and has been a worthwhile procedure. It has given us an opportunity to bridge the time gap that normally elapsed between annual meetings. We want to continue this practice and we hope that your officers and Executive Committee will feel free to call on us at any time for a meeting.

I should like to turn the platform over to Dr. Eliot. At the conclusion of her remarks the Public Health Service and the Children's Bureau will have concluded their roles in the meeting. We will then step aside and Dr. Neupert can take over.

(Applause)

DR. ELIOT: I haven't very much to add, but the one thing I do want to say is how much the Children's Bureau staff appreciates the cooperation that we receive when we are out in the States.

The role of the Children's Bureau is a dual one. Under the Social Security Act we administer the Title with which you are concerned providing grants for maternal and child welfare. We have another role under the Act of creating the Children's Bureau, which gave us the responsibility of looking at all problems of children in the country.

The mandate that comes under that basic Act of the Bureau is an extraordinarily broad one, and one that the Bureau has never undertaken to implement, of course, in totality, because we couldn't. But, as you know, from occasion to occasion we pick up new subjects and we go forward--we try to go forward--helping to create the background, perhaps, I might say to create the atmosphere, for communities, groups of people within communities, voluntary organizations and public organizations, to get at something new in behalf of children. When you find us coming around looking at problems and conditions of child life that seem to be outside of the area of the Social Security Act, I hope you will remember that we are operating under this other broad mandate that Congress gave us more than forty years ago.

I also want to say that every word that Dr. Lesser and I said to you in the remarks we made the other day, of which I was but the mouthpiece, we meant. And I hope that we can go forward and look forward together to many more adventures in this field of maternal and child health and welfare. Also, don't forget that it is very difficult to separate the health and the welfare aspects of the lives of children.

The other day I gave you some figures in the early parts of my remarks, reporting the increases in State contributions to the maternal and child health and crippled children's programs. When I went upstairs just now I found that the graphs which put those figures in more understandable form have just come through. I didn't stop to assemble copies for you at this time, but I hope, when my remarks are published, these graphs will be published with them. Anyone who would like to have copies, of course, can have them.

I would like to say in closing that I believe this meeting has been a good one. I am pleased with the cohesion there seems to be among the health officers. I can look back to the session of 1939 and some of the sessions after 1939. Since then we have moved a very long way in working together, and it has been very satisfactory.

Thank you.

(Applause)

RECOMMENDATIONS

CONFERENCE OF

THE SURGEON GENERAL OF THE PUBLIC HEALTH SERVICE

AND

THE CHIEF OF THE CHILDREN'S BUREAU

WITH

THE STATE AND TERRITORIAL HEALTH OFFICERS

THE STATE MENTAL HEALTH AUTHORITIES

AND

REPRESENTATIVES OF STATE HOSPITAL SURVEY AND CONSTRUCTION AGENCIES

November 7, 1953

ENVIRONMENTAL SANITATION COMMITTEE

Chairman, Wilson T. Sowder, M.D., Florida

Vice-Chairman, G. J. Van Heuvelen, M.D., South Dakota

Members

George W. Cox, M.D.	Texas
John T. Herron, M.D.	Arkansas
Grady F. Mathews, M.D.	Oklahoma
L. J. Peterson, M.S.P.H.	Idaho
Russell E. Teague, M.D.	Pennsylvania

Public Health Service

Mr. Mark D. Hollis (Liaison)
Mr. Harry G. Hanson
Mr. Leonard M. Board
Mr. Carl E. Schwob

The Committee on Environmental Sanitation, with all members present, held an interesting and enlightening discussion on the twenty-one agenda items submitted covering current problem areas in the important field of sanitary engineering. It was brought out forcefully that municipal and industrial expansion is intensifying many of the traditional sanitation problems as well as producing a number of new and more complex environmental problems.

The Committee's recommendations:

1. Air Pollution

That the Public Health Service intensify a program of research including critical evaluation and study of the various health aspects of atmospheric pollution: To determine their nature, causes, and relative importance; to establish principle sources of danger; to develop methods of evaluating community air pollution problems; and to seek practical control measures.

2. Chemical Environment

That the Public Health Service explore vigorously the effects on health of the chemical environment, for the purpose of developing approaches to the control of hazards of health significance.

3. Shellfish Sanitation

That a joint State-Federal-industry conference be called by the Surgeon General to review the present system of shellfish-sanitation control in the United

States and that the Association of State and Territorial Health Officers be officially represented.

4. Limitations on Milk and Food Equipment

That the Public Health Service withdraw the limitations in effect by that agency in regard to inspection, approval and issuance of equipment compliance letters on milk and food equipment which meet requirements of Public Health Service recommended ordinances.

5. Studies of Epidemiological Bases of Sanitation Measures

That studies of epidemiological bases of sanitation measures be undertaken in order to provide indices for evaluating such measures, as recommended by the 1952 Conference of State and Territorial Health Officers, and to provide a baseline for the improvement of sanitation and sanitation training.

FEDERAL RELATIONS COMMITTEE

Chairman, Herman E. Hilleboe, M.D., New York

Vice-Chairman, N. H. Dyer, M.D., West Virginia

Members

R. B. Aiken, M.D.*	Vermont
R. L. Cleere, M.D.	Colorado
Albert E. Heustis, M.D.	Michigan
Daniel J. Hurley, M.D.	Nevada
Mack I. Shanholtz, M.D.	Virginia
Felix J. Underwood, M.D.	Mississippi

Public Health Service

Dr. Jack C. Haldeman (Liaison)
Dr. Aaron W. Christensen
Mr. Sam A. Kimble
Dr. C. J. Van Slyke

Children's Bureau

Dr. Arthur J. Lesser
Mr. John C. McDougall

The Committee's recommendations:

1. Financial Need Factor

That no change be made in the present grant-in-aid formula pending (1) a clarification of the entire grant-in-aid picture and (2) the release of the report of the Commission on Inter-Governmental Relations (Manion Commission).

*Absent

2. Publication of Conference Proceedings

That the proceedings of the Conference of the Surgeon General of the Public Health Service and the Chief of the Children's Bureau with the State and Territorial Health Officers, the State Mental Health Authorities and representatives of State Hospital Survey and Construction Agencies be published and distributed annually to conference participants and on request to other interested individuals and groups.

3. Specialized Expenditure Requirements

That the question of permitting State health agencies to use a portion of State appropriations for generalized public health nursing services for matching purposes in meeting the 80% specialized expenditure requirement be referred to the Subcommittee on Fiscal Affairs for further study.

4. Recommendation No. 3--Federal Relations Committee (1952)

That the question of the repeal of Public Health Service Regulation 51.6 and Children's Bureau Regulation 200.18 pertaining to validation of categorical grants be re-opened.

A recommendation for the repeal of these regulations was contained in Recommendation No. 3 of the report of the Federal Relations Committee at the 1952 Conference. The Children's Bureau and the Public Health Service did not concur in this recommendation. The Committee believes, however, that the question should be considered further by the Public Health Service and the Children's Bureau.

5. Records and Reports

The following report forms, which were submitted by the Public Health Service and the Children's Bureau to the Subcommittee on Records and Reports for study, are approved by the Conference:

a. Joint Form 5—State Report of Personnel by Organizational Unit

b. Revised Joint Forms 3 and 11.1—The Financial Report Forms of the Public Health Service and the Children's Bureau, respectively

c. Revised Report Forms of the Public Health Service Venereal Disease Division

d. Interim Revision of the Annual Report of Public Health Personnel, Facilities, and Services--Major changes in this report are under study

e. Joint Public Health Service--Children's Bureau State Health Plan Document--Studies to simplify and improve this document will be continued

f. Annual Statistical Report of Outpatient Psychiatric Clinics

6. Development of Quantitative and Qualitative Measurements for use in Evaluating Public Health Programs

That a joint committee be established representing the Public Health Service, Children's Bureau, and the Association of State and Territorial Health Officers to

develop quantitative and qualitative measurements which could be used to evaluate public health programs.

The changing character of public health makes it necessary to develop new criteria for evaluation of public health practices. The major attempts in this field are being made by academic and voluntary agencies and there is need for the official health agencies to enter this field and from their experience develop workable and practical criteria. Changing patterns of Federal aid to States and State aid to local health units make such an activity even more important at this time.

HOSPITAL COMMITTEE

Chairman, Wilton L. Halverson, M.D.,* California
(Dr. Robert Dyar represented California)

Vice-Chairman, John J. Bourke, M.D., New York

Members

Arthur G. Burns	Florida
Roland R. Cross, M.D.	Illinois
Edmund G. Zimmerer	Iowa
Edward D. Grant, Ph.D.*	Louisiana
(E. R. Anderson represented	Louisiana)
Robert H. Riley, M.D.	Maryland
Foster L. Fowler	Mississippi
Sanford Bates	New Jersey
John A. Ferrell, M.D.	North Carolina

Public Health Service

Dr. John W. Cronin (Liaison)
Dr. Vane M. Hoge
Dr. Edward T. Thompson
Mr. Charles Hilsenroth

Children's Bureau

Miss Ruth Doran

The Committee's recommendations:

1. Appraisal of Facilities Assisted Under the Hospital Survey and Construction Act

That in placing continued emphasis on the appraisal of general hospitals constructed under the Hill-Burton Program extension of the system of evaluation be made to include all facilities constructed under that program.

*Absent

2. Termination of Projects

That the Conference endorse the practice of terminating projects under present authority as early as practical without jeopardizing the interests of individual project sponsors.

3. Public Hearings on State Plan Revisions

That the Secretary of the Department of Health, Education, and Welfare and Federal Hospital Council amend the regulations requiring public hearings on State Plan revision so that hearings would be discretionary with the State.

4. Study of Formula Governing Allotment of Hospital Construction Funds

That the study and evaluation of the formula governing annual allotment of hospital construction funds to States be continued by the Public Health Service.

5. Split Projects

That the split project technique of approving hospital projects utilized since the start of Hill-Burton program, be continued and that no additional administrative policies be promulgated that will result in an added financial burden to sponsors or that will delay the start and completion of urgently needed hospital facilities.

6. Rate of Participation in Hill-Burton Projects

That in order further to promote construction of facilities for all types of chronic care, tuberculosis, mental disease, and public health services, the Public Health Service explore jointly with representatives of the State agencies, financial means of stimulating such construction.

7. Number of Hospital Beds Required

That the per capita requirements for hospital beds be kept under continuous study by the U. S. Public Health Service and other appropriate agencies.

That the Public Health Service planning for proposed conferences of State Hospital Program directors and the Federal Hospital Council include participation of and consultation from representatives of the State Hospital Program Directors.

INFECTIOUS DISEASES COMMITTEE

Chairman, T. F. Sellers, M.D., Georgia

Vice-Chairman, Franklin D. Yoder, M.D., Wyoming

Members

Roy A. Anduze, M.D.	Virgin Islands
D. G. Gill, M.D.	Alabama
Dean H. Fisher, M.D.	Maine
E. A. Rogers, M.D.	Nebraska
Ben F. Wyman, M.D.	South Carolina

Public Health Service

Dr. Theodore J. Bauer (Liaison)
Dr. Robert J. Anderson
Dr. Carl C. Dauer
Dr. Alexander D. Langmuir
Dr. James Steele

Children's Bureau

Dr. Marian M. Crane

The Committee's recommendations:

1. Field Refresher Courses in Laboratory Technology

That the U. S. Public Health Service be encouraged to extend its field refresher courses to cover subjects in bacteriology, mycology, parasitology and to extend courses now available; said courses now available; said courses to be given with cooperation of existing health laboratories and to be open to all qualified laboratory personnel in each State.

2. Leptospirosis

Approving the action taken to date by the Public Health Service in investigating the problem of leptospirosis, that the control of this disease in man and animal be further investigated and reported on at the next annual meeting.

3. Testing of Blood Donors

That the Public Health Service investigate the possibility of practical tests to be used routinely on blood donors for the purpose of eliminating potential sources of serum hepatitis.

4. Notification of Influenza Virus Isolation

That the Public Health Service be encouraged to take all steps to inform State health officers when it appears that an influenza outbreak is impending.

5. Preparation and Distribution of Diagnostic Reagents

That the Public Health Service take appropriate steps to make available to State laboratories those diagnostic antigens and antisera which are not available commercially.

6. Uniform Morbidity Reporting

That the Surgeon General of the Public Health Service be requested to sponsor during the year 1954 a National Conference of State Epidemiologists.

7. Use of Chick Embryo Anti-Rabies Vaccine

That the Public Health Service be requested to investigate the problem of rabies in bats in the United States.

MATERNAL AND CHILD HEALTH COMMITTEE

Chairman, G. D. Carlyle Thompson, M.D., Montana

Vice-Chairman, Thomas R. Hood, M.D., Kansas

Members

James R. Amos, M.D.	Missouri
Floyd I. Hudson, M.D.	Delaware
Samuel B. Kirkwood, M.D.	Massachusetts
Richard K. C. Lee, M.D.	Hawaii
Edward A. McLaughlin, M.D.*	Rhode Island
(James P. Deery, M.D., represented	Rhode Island)

Public Health Service	Children's Bureau
Dr. Thomas L. Hagan	Dr. Lucille J. Marsh (Liaison)
Mr. Sam Shapiro	Dr. John T. Fulton
Dr. Mayhew Derryberry	Miss Ruth Taylor
	Miss Helen Stacey

The Committee's recommendations:

1. Child Development Training

It is recommended that opportunities be provided by State and Territorial health departments for the training of their own staff physicians dealing with children and for the training of physicians in practice dealing with children in order that up-to-date information be acquired on child development so that nation-wide recognition be given this area of knowledge as a public health concern.

2. Fetal-Neonatal Pathology

It is recommended that in order to better understand factors which may help in reducing fetal and neonatal deaths the State and Territorial Health Officers should:

(1) Encourage more training programs directed toward providing pathologists with special interest and understanding of gross and microscopic pathology of the near birth and newborn stages of development and directed toward helping medical hospital staff in interpreting pathological findings.

(2) Request the Joint Committee of the American Medical Association and American Hospital Association to revise its 1939 ruling on computation of necropsy rates for accrediting hospitals so that some consideration is given to postmortems on fetuses of 20 weeks and over, at least in the ratio of these fetal deaths to total deaths in hospitals.

*Absent

3. Peri-Natal Mortality Study

It is recommended that State and Territorial Health Officers consider the advisability of initiating a peri-natal mortality study.

4. Military and Civilian Responsibilities for Maternal and Child Health

It is recommended that State and Territorial health departments make special effort to cooperate with local commanders of military installations in supplementing maternal and child care services for dependents and that particular emphasis might be placed upon conducting classes for prospective parents and helping provide care for crippled children.

MENTAL HEALTH COMMITTEE

Chairman, J. W. R. Norton, M.D., North Carolina

Vice-Chairman, Joseph E. Barrett, M.D., Virginia

Members

W. P. Beckman, M.D.	South Carolina
Newton J. T. Bigelow, M.D.*	New York
(Ernest Gruenberg, M.D., represented	New York)
Mr. Alan Reynolds*	Pennsylvania
(Mrs. Dorothy Sheeley represented	Pennsylvania)
Jack R. Ewalt, M.D.	Massachusetts
Edward D. Grant, Ph.D*	Louisiana
Mr. John L. Lamneck*	Ohio
Mr. Jarle Leirfallom*	Minnesota
(Mrs. Constance Carlgren represented	Minnesota)
Wilbur Miller, M.D.	Iowa
Margaret Morgan, M.D.*	Indiana
Anna L. Philbrook, M.D.	New Hampshire
Mr. Edward P. Reidy*	Rhode Island
Clarence G. Salsbury, M.D.	Arizona
Otto L. Bettag, M.D.*	Illinois
Frank M. Gaines, M.D.	Kentucky
Daniel L. Seckinger, M.D.*	District of Columbia
(Frederick Heath, M.D., represented	District of Columbia)
R. J. Spratt, M.D.*	Montana
E. H. Crawfis, M.D.	California
M. A. Tarumianz, M.D.*	Delaware
Mr. John W. Tramburg*	Wisconsin
Mr. Charles F. Wagg	Michigan
Cyril J. Ruilman, M.D.	Tennessee

*Absent

Public Health Service

Dr. James V. Lowry (Liaison)
Dr. Curtis G. Southard
Mrs. Alice Spillane
Dr. Jerry W. Carter, Jr.

The Committee's recommendations:

1. Annual Statistics on Psychiatric Outpatient Facilities

That the annual statistical report of outpatient psychiatric clinics, developed by the National Institute of Mental Health in consultation with State Mental Health Authorities and representative professional organizations, be made available for nationwide use on July 1, 1954.

2. Field Studies to be Made by NIMH in Cooperation with States

That the National Institute of Mental Health cooperate with States and localities in setting up field investigations relative to mental health.

SPECIAL HEALTH AND MEDICAL SERVICES COMMITTEE

Chairman, John A. Kahl, M.D.,* Washington
(Jess Speilholz, M.D., represented Washington)

Acting Chairman, C. Earl Albrecht, M.D., Alaska

Members

S. J. Phillips, M.D.	Louisiana
Gerald R. Clark, M.D.	New Mexico
George A. Spendlove, M.D.	Utah
John Samuel Wheeler, M.D.	New Hampshire
Juan A. Pons, M.D.*	Puerto Rico

Public Health Service

Dr. Seward E. Miller (Liaison)
Dr. Arnold B. Kurlander
Dr. James Watt
Dr. Samuel C. Ingraham
Mrs. Lucile P. Leone
Dr. C. B. Spencer
Dr. James K. Shafer
Dr. Donald J. Galagan

Children's Bureau

Dr. John Saunders
Miss Edith Baker
Miss Clara Arrington
Miss Marjorie Heseltine
Dr. Katherine Bain

*Absent

The Committee's recommendations:

1. Fluoridation of Communal Water Supplies

It is recommended that the Department of Health, Education, and Welfare develop jointly with the State and Territorial Health Officers and their Dental Directors a plan to further expand, emphasize and distribute information concerning the values of fluoridating water systems deficient in fluoride.

2. Mexico Border Sanitation

It is recommended that the Federal Government be urged to carry on a more comprehensive program for the protection of public health from the hazards existent along the United States--Mexico border, and that the Public Health Service initiate action with the appropriate agencies.

3. Radiation Hazard Control

It is recommended that health departments strengthen State and local programs for controlling hazards associated with the various sources of radiation and radioactive material; that the Public Health Service (1) continue to provide appropriate State and Territorial health authorities with information concerning radiation hazards and methods for conducting effective inspection and control programs; (2) continue its training program; and (3) request the Atomic Energy Commission and its contractors to provide opportunity for training at their installations where feasible.

4. Screening of Immigrants to the United States

It is recommended that uniform and effective methods of physical examination and laboratory studies be applied in screening applicants for admission into the United States and that sufficient funds be made available to permit adequate implementation of this program.

5. Venereal Disease Control Programs

It is agreed that the Association of State and Territorial Health Officers further study and evaluate State venereal disease programs from the point of view of Federal responsibility and State responsibility and that a Venereal Disease Advisory Committee be appointed to work with the Public Health Service in making out this study and evaluation. It is recommended that the Public Health Service continue to support VD interview-investigative services in areas of national concern--military, defense, and military-defense recreational areas, particularly in those areas which have not been able to reach control status.

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